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Case-Based Health Law Teaching for Undergraduate Rehabilitation Therapy Students: A Single-Group Pre-Post Educational Intervention Study

Qian Zhang
Affiliated Hospital of Guizhou Medical University
Shuang Wu
Affiliated Hospital of Guizhou Medical University
Lijun Xiao
294394336@qq.com

ShenQi Ethnic Medicine College of Guizhou Medical University
Guoyu Chen
Affiliated Hospital of Guizhou Medical University
Jue Long
Guizhou Medical University

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Abstract

Background

Undergraduate rehabilitation therapy programs emphasize clinical knowledge and technical competence, but students also need basic legal literacy to manage informed consent, risk disclosure, privacy protection, documentation, and patient-therapist disputes in clinical practice. This study evaluated whether a case-based health law teaching intervention improved legal knowledge and clinical legal risk identification among undergraduate rehabilitation therapy students.

Methods

We conducted a single-group pre-post educational intervention study among 102 undergraduate rehabilitation therapy students at Guizhou Medical University and the Affiliated Hospital of Guizhou Medical University. The intervention consisted of 18 teaching hours of case-based health law teaching focused on informed consent, medical risk disclosure, patient-therapist communication, prevention and management of medical disputes, legal awareness, and current approaches to preventing doctor-patient conflict. Students completed assessments before and after the intervention. The primary outcomes were legal knowledge score and clinical legal risk identification score, each measured on a 0-100 scale. Secondary outcomes were learning attitude and course satisfaction, each measured on a 1–5 Likert scale. Paired t tests were used for pre-post comparisons, with Wilcoxon signed-rank tests as sensitivity analyses. Exact McNemar tests were used to compare mastery rates, defined as scores of 70 or higher.

Results

Of the 102 students, 39 (38.2%) were third-year students and 63 (61.8%) were fourth-year students or interns. Legal knowledge scores increased from 50.76 (SD 13.03) before the intervention to 80.64 (SD 12.29) after the intervention, with a mean paired difference of 29.89 points (95% CI, 28.38 to 31.39; $p < 0.001$; Cohen's dz = 3.86). Clinical legal risk identification scores increased from 50.03 (SD 10.36) to 76.85 (SD 10.79), with a mean difference of 26.82 points (95% CI, 25.41 to 28.24; $p < 0.001$; Cohen's dz = 3.68). Learning attitude increased from 3.48 (SD 0.56) to 4.30 (SD 0.49), and course satisfaction increased from 3.39 (SD 0.52) to 4.26 (SD 0.52). The proportion of students reaching the mastery threshold increased from 5.9% to 80.4% for legal knowledge and from 2.9% to 77.5% for risk identification. Exploratory analyses showed similar improvement patterns in third-year students and fourth-year/internship-stage students.

Conclusions

A case-based health law teaching intervention was associated with substantial improvements in legal knowledge, clinical legal risk identification, learning attitude, and course satisfaction among undergraduate rehabilitation therapy students. These findings suggest that clinically situated health law teaching may be a feasible addition to rehabilitation therapy curricula, particularly before or during clinical internship. Controlled multi-institutional studies are needed to evaluate durability, transfer to clinical behavior, and generalizability.

Background

Rehabilitation therapy students are trained to assess function, implement therapeutic techniques, communicate with patients and families, and participate in multidisciplinary care. As students move from classroom learning into clinical placement, they also encounter legal and ethical issues that are tightly linked to daily rehabilitation practice: informed consent, risk disclosure, patient privacy, clinical documentation, treatment boundaries, and the handling of patient complaints. These issues are not peripheral to professional competence. They shape how rehabilitation therapists explain treatment risks, protect patient rights, and respond to clinical uncertainty. Contemporary health professions education has increasingly emphasized competency, systems thinking, and preparation for practice rather than knowledge transmission alone [1]. Informed consent increasingly emphasizes information that is meaningful to a reasonable patient and is closely linked to shared decision making [2], while effective clinical communication requires structured attention to patient concerns, information sharing, shared understanding, and closure of the encounter [3].

Health law education has practical importance in rehabilitation therapy because treatment often involves repeated patient contact, hands-on procedures, functional training, and communication with patients who may have disability, chronic illness, impaired mobility, or complex family involvement. Professional education in physiotherapy and rehabilitation-related disciplines is expected to support safe, ethical, and competent practice across clinical contexts [4]. The World Health Organization Rehabilitation Competency Framework similarly emphasizes values, behaviours, knowledge, and skills required for rehabilitation practice and service delivery [5]. Patient-safety education also encourages multi-professional teaching that helps learners recognize risk, communicate effectively, and apply safety concepts in practice [6]. Students who lack legal knowledge may recognize that law is relevant to clinical work but still be unable to apply legal principles to specific situations. Preliminary local teaching experience in our setting suggested that rehabilitation therapy students had limited familiarity with relevant health laws but expressed strong willingness to learn through case analysis, lectures, and compulsory course formats.

The legal risk profile of rehabilitation therapy differs in some respects from that of physician-led diagnosis or surgery. Rehabilitation treatment is usually longitudinal, function-oriented, and delivered through repeated therapist-patient interactions. A single patient may receive multiple sessions involving manual techniques, exercise prescription, physical agents, gait training, balance training, assistive-device instruction, and home-exercise education. The therapeutic effect often depends on patient cooperation

and family participation, which increases the importance of communication, documentation, and shared understanding of treatment goals. Students therefore need more than general legal awareness. They need to recognize how legal principles are expressed in ordinary rehabilitation encounters: explaining foreseeable risks before treatment, documenting patient refusal or poor adherence, protecting privacy during bedside training, and clarifying professional boundaries when patients request interventions outside standardized indications.

Case-based learning may be particularly suitable for health law education. Legal knowledge is difficult for students to apply when it is taught as abstract rules. In contrast, clinically situated cases allow learners to identify risk, discuss decision points, and connect legal requirements with professional behavior. A BEME systematic review found that learners generally value case-based learning and perceive it as supportive of learning, while also noting that comparative evidence on learning outcomes varies across contexts [7]. For rehabilitation therapy students, cases can be designed around realistic scenarios such as inadequate risk disclosure before physical therapy, privacy breaches during ward-based training, disagreement about treatment goals, inappropriate extension of therapist practice boundaries, or disputes arising during internship.

Despite this need, empirical evidence for health law teaching in rehabilitation therapy education remains limited. Many studies of medical law education focus on medical students or general health professions learners, while rehabilitation therapy students are often treated as a subgroup of broader medical education rather than as a distinct learner population. Their clinical roles, supervision patterns, and exposure to patient contact differ from those of medical students, making discipline-specific educational evaluation necessary.

This study evaluated a case-based health law teaching intervention for undergraduate rehabilitation therapy students. We hypothesized that the intervention would improve students' legal knowledge and clinical legal risk identification. We also examined changes in learning attitude and course satisfaction as secondary outcomes.

Methods

Study design and setting

We conducted a quasi-experimental single-group pre-post educational intervention study at Guizhou Medical University and the Affiliated Hospital of Guizhou Medical University in Guiyang, Guizhou Province, China. The study was designed as a pragmatic educational evaluation of a case-based health law teaching module delivered to undergraduate rehabilitation therapy students. The study followed a pre-post assessment structure: all participants completed the same assessment before and after the teaching intervention.

Participants

Participants were undergraduate rehabilitation therapy students who were in the third year, fourth year, or internship stage during the study period. Students were eligible if they were enrolled in the rehabilitation therapy program and participated in the health law teaching activity. Students were excluded if they did not complete either the pre-intervention or post-intervention assessment. A total of 102 students were included in the analysis.

Teaching intervention

The intervention was a case-based health law teaching module developed for rehabilitation therapy students. The module consisted of 18 teaching hours and covered six content areas: informed consent, medical risk disclosure, patient privacy, medical damage liability, therapist practice boundaries, and legal risk management in rehabilitation-related disputes. The legal content was aligned with current Chinese civil law provisions relevant to patient rights, medical damage liability, and professional responsibility [11]. Teaching cases were adapted from common rehabilitation-related clinical and medico-legal situations, including prevention and management of medical disputes, improvement of patient-therapist communication, cultivation of legal awareness, and analysis of the current status and prevention strategies for doctor-patient conflicts.

The 18 teaching hours were organized as a thematic module rather than as isolated lectures. The first component introduced the legal responsibilities of rehabilitation therapists and the relationship between patient rights, professional conduct, and clinical risk prevention. The second component focused on patient-therapist communication and medical risk disclosure, using cases in which insufficient explanation of treatment risks could lead to misunderstanding or complaint. The third component addressed privacy, documentation, and medical damage liability through examples from rehabilitation wards and internship settings. The final component integrated these topics through case discussion and scenario-based risk identification, asking students to analyze how a dispute developed, which communication or documentation steps were missing, and how the therapist could respond more appropriately. To improve intervention transparency and replicability, the curriculum blueprint was reported in a structured form consistent with the rationale of intervention-reporting guidance such as TIDieR [8]. A detailed curriculum blueprint is provided in Supplementary Table 1.

Each case followed a common teaching sequence. First, students reviewed a short clinical scenario and identified the key rehabilitation procedure, patient concern, and potential legal issue. Second, instructors guided students to connect the scenario with relevant legal and ethical principles. Third, students discussed possible responses in small groups, including what should be explained to the patient or family, what should be documented, and when a supervisor or multidisciplinary team member should be involved. Finally, instructors summarized the legal risk points and linked them back to routine rehabilitation practice. This structure was intended to shift learning from memorization of legal provisions to applied risk recognition and communication planning. The case-analysis sequence is summarized in Supplementary Table 2, and a representative composite case vignette with a scoring rubric excerpt is provided in Supplementary Tables 5 and 6.

The intervention was delivered by instructors with backgrounds in medicine, medical law, and ethics. The interdisciplinary teaching team was intended to ensure that cases were both clinically authentic and legally accurate. Medical instructors helped situate the cases in rehabilitation workflow, while medical law and ethics instructors clarified legal concepts, patient rights, liability issues, and ethical reasoning.

Outcome measures

The primary outcomes were legal knowledge and clinical legal risk identification. Legal knowledge was assessed with a 0-100 score based on questions covering basic health law concepts relevant to rehabilitation therapy, including informed consent, patient rights, privacy, documentation, and liability. Clinical legal risk identification was assessed with a 0-100 score based on scenario or vignette items requiring students to recognize legal risks in rehabilitation practice.

The assessment was designed to reflect both knowledge acquisition and early applied reasoning. Legal knowledge items focused on whether students understood basic concepts and responsibilities. Risk identification items focused on whether students could detect legally relevant problems in a realistic clinical situation, such as incomplete risk disclosure, unclear consent, inappropriate communication with family members, inadequate privacy protection, or poor documentation after a complaint. The same scoring framework was used before and after the intervention so that paired changes reflected change within the same learners. The analysis dataset available for this study contained domain-level scores rather than item-level responses; therefore, item-level performance, internal consistency, and detailed item overlap between pre- and post-intervention assessments could not be evaluated in the present analysis. The outcome domains and scoring framework are summarized in Supplementary Table 3. Because the assessment was designed for this course evaluation rather than as a previously validated external instrument, the results should be interpreted as evidence of short-term course-aligned learning rather than definitive proof of durable clinical competence.

Secondary outcomes were learning attitude and course satisfaction, both measured on a 1–5 Likert scale. Higher scores indicated a more positive learning attitude or greater satisfaction. A mastery threshold of 70 points was prespecified for legal knowledge and risk identification.

Data collection

Students completed the pre-intervention assessment before the case-based teaching session and the post-intervention assessment after the teaching intervention. Data were exported to Excel and analyzed after de-identification. The analysis dataset contained student ID codes, grade category, and pre-post scores for the four outcomes. It did not contain names, contact information, or other directly identifying personal information. Individual scores were used only for paired educational evaluation and statistical analysis, and results are reported only in aggregate. No missing values were present in the analysis dataset.

Statistical analysis

Continuous outcomes were summarized as means and standard deviations. Paired differences were calculated as post-intervention score minus pre-intervention score. Normality of paired differences was assessed using the Shapiro-Wilk test. Paired t tests were used for the main pre-post comparisons, and Wilcoxon signed-rank tests were performed as sensitivity analyses. Effect sizes were reported as Cohen's dz for paired samples. For the two 0-100 primary outcomes, mastery rates were compared before and after the intervention using exact McNemar tests. Exploratory grade-stratified analyses compared change scores between third-year students and fourth-year/internship-stage students using Welch's two-sample t tests. These subgroup analyses were descriptive and were not treated as primary hypothesis tests. All analyses were conducted using Python with pandas, scipy, numpy, and matplotlib. A two-sided p value of less than 0.05 was considered statistically significant.

Ethical considerations

The study protocol was submitted to and reviewed by the Ethics Committee of the Affiliated Hospital of Guizhou Medical University (Guiyang, China), which determined that this minimal-risk educational evaluation was exempt from formal ethics approval because it did not involve human experimentation and used de-identified student assessment data. The ethics exemption reference number was 2024 Lun Shen No. 338 (2024□□□[338]□). The study was conducted in accordance with relevant institutional guidelines and regulations and with the principles of the Declaration of Helsinki. All participants were informed about the educational evaluation and provided informed consent to participate. Participation was voluntary, and student data were analyzed using de-identified codes.

Results

Participant characteristics

The analysis included 102 undergraduate rehabilitation therapy students. Thirty-nine students (38.2%) were in Year 3, and 63 students (61.8%) were in Year 4 or the internship stage (Table 1). There were no missing values for any pre-intervention or post-intervention outcome.

Primary outcomes

Legal knowledge improved substantially after the intervention. The mean legal knowledge score increased from 50.76 (SD 13.03) before the intervention to 80.64 (SD 12.29) after the intervention, corresponding to a mean paired difference of 29.89 points (95% CI, 28.38 to 31.39; paired $t = 38.97$; $p < 0.001$; Cohen's $dz = 3.86$). The Shapiro-Wilk test did not indicate a major deviation from normality for the paired differences ($W = 0.989$; $p = 0.598$), and the Wilcoxon signed-rank sensitivity analysis was consistent with the main result ($p < 0.001$). The aggregate pre-post changes in the two primary outcomes are shown in Fig. 1.

Clinical legal risk identification also improved after the intervention. The mean score increased from 50.03 (SD 10.36) to 76.85 (SD 10.79), with a mean paired difference of 26.82 points (95% CI, 25.41 to 28.24; paired t = 37.19; p < 0.001; Cohen's dz = 3.68). The paired differences were approximately normally distributed (Shapiro-Wilk W = 0.981; p = 0.144), and the Wilcoxon signed-rank test again supported the main finding (p < 0.001). Individual paired changes for the two primary outcomes are shown in Fig. 2.

Secondary outcomes

Learning attitude improved from 3.48 (SD 0.56) before the intervention to 4.30 (SD 0.49) after the intervention, with a mean paired difference of 0.82 points (95% CI, 0.77 to 0.87; p < 0.001; Cohen's dz = 3.01). Course satisfaction improved from 3.39 (SD 0.52) to 4.26 (SD 0.52), with a mean paired difference of 0.87 points (95% CI, 0.83 to 0.92; p < 0.001; Cohen's dz = 3.45). Although the paired differences for learning attitude showed some departure from normality (Shapiro-Wilk W = 0.968; p = 0.014), the Wilcoxon signed-rank test remained statistically significant (p < 0.001).

Mastery rates

Before the intervention, 6 students (5.9%) reached the mastery threshold for legal knowledge. After the intervention, 82 students (80.4%) reached this threshold; 76 students improved from non-mastery to mastery, and no student moved from mastery to non-mastery (exact McNemar p < 0.001). For clinical legal risk identification, the mastery rate increased from 3 students (2.9%) to 79 students (77.5%); 76 students improved from non-mastery to mastery, and no student lost mastery status (exact McNemar p < 0.001).

Exploratory grade-stratified analyses

Exploratory analyses suggested that improvement patterns were similar across grade groups (Supplementary Table 4). For legal knowledge, the mean change was 30.12 (SD 8.17) points among Year 3 students and 29.74 (SD 7.54) points among Year 4 or internship-stage students (between-group p = 0.812). For clinical legal risk identification, the corresponding mean changes were 27.31 (SD 7.31) and 26.52 (SD 7.31) points (between-group p = 0.601). Changes in learning attitude and course satisfaction also did not differ significantly between grade groups. These analyses were exploratory and should be interpreted descriptively rather than as evidence of subgroup equivalence.

Discussion

This single-group pre-post educational intervention study found that case-based health law teaching was associated with large improvements in legal knowledge and clinical legal risk identification among undergraduate rehabilitation therapy students. The improvement was consistent across objective 0-100 assessment scores and self-reported learning outcomes. Mastery rates also increased markedly after the intervention, suggesting that the course did not merely shift average scores but moved a substantial proportion of students above a predefined competence threshold. The size and consistency of the

changes indicate that legal education can be made visible and measurable in a rehabilitation therapy curriculum, even when delivered as a focused module rather than a full-semester course.

The findings are educationally plausible, but they should be interpreted as short-term course-aligned learning outcomes. Health law is often difficult for students when presented as statutes or abstract principles. Case-based teaching gives learners a concrete context in which they can recognize patient rights, identify risk disclosure obligations, and discuss appropriate professional responses. For rehabilitation therapy students, this context is especially important because clinical practice involves repeated patient contact, physical interaction, individualized treatment planning, and frequent communication with families and multidisciplinary teams. A case-based approach may therefore connect legal knowledge with the specific situations students are likely to face during internship.

One possible mechanism is contextualization. Students may find it hard to retain isolated legal concepts, but they can more readily understand why those concepts matter when they are embedded in an event: a patient questions the necessity of a treatment, a family member complains that risks were not explained, or a therapist documents an adverse response incompletely. The case gives students a sequence of actions and omissions to analyze. It also gives instructors an opportunity to ask not only "Which rule applies?" but also "What should the therapist say, record, and escalate?" This may explain why gains were seen not only in legal knowledge but also in risk identification.

Another possible mechanism is the integration of legal reasoning with communication training. Medical disputes often arise not only from technical errors but also from inadequate explanation, inconsistent expectations, poor documentation, or delayed response to dissatisfaction. A rehabilitation therapist's legal literacy is therefore inseparable from communication competence. In this study, the teaching cases deliberately linked legal awareness with doctor-patient conflict prevention and patient-therapist communication, consistent with broader communication frameworks that emphasize information sharing, shared understanding, and negotiated plans [5]. This design may be more relevant to rehabilitation therapy students than a conventional law course organized only around legal categories.

The largest gains were observed in legal knowledge and risk identification. These domains are closely aligned with the intervention content and may represent the most immediate learning outcomes of a short health law module. Improvements in learning attitude and course satisfaction suggest that students accepted the teaching format and perceived the course as relevant. However, attitude and satisfaction should not be interpreted as evidence of clinical behavior change. This interpretation is consistent with critiques of using Kirkpatrick-style educational outcomes mechanically: learner reaction and knowledge acquisition are useful but do not by themselves establish transfer to practice or patient-level impact [9]. Higher-level outcomes, such as performance in standardized patient encounters, quality of risk disclosure, documentation behavior, or handling of patient complaints during internship, require further evaluation.

The magnitude of the observed improvement also requires cautious interpretation. The large effect sizes may partly reflect the alignment between the teaching content and the assessment, the short interval

between instruction and post-intervention testing, and possible familiarity with the assessment format. These features are common in pragmatic course evaluations but limit causal inference. For this reason, the main conclusion should be that the module was associated with substantial short-term gains in course-aligned knowledge and risk-recognition scores, not that it has been proven to reduce real-world medical disputes or improve clinical legal behavior.

The study has implications for curriculum design in rehabilitation therapy education. First, health law teaching should be positioned close to clinical exposure, when students can connect legal rules with patient care. The Year 3 to internship stage may be a practical window for such teaching because students have acquired foundational rehabilitation knowledge and are beginning to encounter real patient communication, treatment explanation, and dispute-prevention tasks. Second, the curriculum should include scenario-based assessment rather than relying only on knowledge questions. Risk identification is a more practice-oriented endpoint and may better reflect students' readiness for clinical placement. Third, collaboration between rehabilitation medicine educators and legal or ethics educators may strengthen the authenticity and accuracy of teaching cases.

The 18-hour format used in this study may also be practical for curriculum adoption. It is long enough to cover several recurring legal risk domains, yet short enough to be embedded into an existing rehabilitation therapy curriculum as a thematic module. For institutions that cannot immediately establish a full health law course, an 18-hour case-based module could serve as a transitional model. The module can be linked to clinical internship preparation, professionalism education, or interprofessional communication training. In this form, legal education is not treated as a separate theoretical topic but as part of the professional reasoning students need when they explain treatment, document care, communicate with families, and respond to complaints.

For curriculum planners, the findings suggest several practical design principles. The first is timing: legal education should not be limited to early general education courses, where students have little clinical context, nor delayed until after students have already entered practice. The second is authenticity: cases should be drawn from real or realistic rehabilitation situations rather than generic medical disputes. The third is interdisciplinarity: medical law teachers can clarify legal doctrine, but rehabilitation educators are needed to show how those doctrines appear in daily treatment. The fourth is assessment alignment: if the goal is safer clinical practice, then assessment should include case-vignette risk recognition, not only recall of legal terms.

For international readers, the specific legal provisions differ by jurisdiction, but the educational problem is transferable. Rehabilitation therapy students in many systems must learn how to communicate risk, respect patient rights, protect privacy, and respond to disputes within supervised clinical practice. The content of local statutes should therefore be adapted to each country or region, while the pedagogical structure can remain similar: select authentic cases, require students to identify the legal and communication risks, guide them to propose an appropriate response, and assess both knowledge and applied risk recognition.

This study also has limitations. The single-group pre-post design cannot exclude alternative explanations such as test familiarity, maturation, short-term assessment effects, or general increased attention to legal topics during the teaching period. The study was conducted at a single institution, limiting generalizability. The outcomes were measured immediately after the intervention, so the durability of learning is unknown. The assessment instrument was course-aligned and requires further validation, including item analysis, internal consistency testing, external expert review of scenario items, and evidence that performance predicts later clinical behavior. Because only domain-level scores were available in the analysis dataset, Cronbach's alpha, item difficulty, item discrimination, and detailed pre-post item overlap could not be assessed. The study did not measure behavior in real clinical settings. Finally, because all students received the intervention, we could not compare case-based teaching with lecture-only teaching, routine teaching, or no additional teaching.

Several methodological issues should be addressed in future work. First, delayed post-tests would show whether knowledge and risk identification are retained after students enter internship. Second, objective structured clinical examination stations, standardized patient encounters, or simulation-based assessments could assess whether students can perform risk disclosure, patient-therapist communication, and documentation tasks, rather than only identify risks on paper. Simulation-based medical education has been shown to be most useful when feedback, repetitive practice, curriculum integration, and clearly defined learning outcomes are present [10], features that could inform the next version of this module. Third, cluster-randomized or stepped-wedge designs could compare case-based teaching with routine teaching while remaining feasible within an educational program. Fourth, multi-institutional studies could examine whether the module works similarly in programs with different curriculum structures, internship arrangements, and local legal environments.

Conclusions

Case-based health law teaching was associated with substantial short-term improvements in legal knowledge, clinical legal risk identification, learning attitude, and course satisfaction among undergraduate rehabilitation therapy students. The results suggest that clinically situated legal education may be feasible and educationally useful before or during clinical internship. Further controlled studies are needed to examine retention, behavioral transfer, and generalizability.

Abbreviations

BEME
Best Evidence Medical Education
CI
confidence interval
OSCE
Objective Structured Clinical Examination
SD

standard deviation
TIDieR
Template for Intervention Description and Replication
WHO
World Health Organization.

Declarations

AI-assisted writing disclosure

An artificial intelligence language model was used to assist with manuscript drafting, statistical code organization, and language editing. All statistical results were generated from the provided dataset using reproducible code and were reviewed by the authors. The authors retain full responsibility for the content of the manuscript.

Ethics approval and consent to participate:

The study protocol was submitted to and reviewed by the Ethics Committee of the Affiliated Hospital of Guizhou Medical University (Guiyang, China), which determined that this minimal-risk educational evaluation was exempt from formal ethics approval because it did not involve human experimentation and used de-identified student assessment data. The ethics exemption reference number was 2024 Lun Shen No. 338. The study was conducted in accordance with relevant institutional guidelines and regulations and with the principles of the Declaration of Helsinki. All participants were informed about the educational evaluation and provided informed consent to participate. Participation was voluntary, and all data were analyzed using de-identified student codes.

Consent for publication:

Not applicable.

Competing interests:

The authors declare that they have no competing interests.

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Author Contribution

Q Z, S W, and G C contributed to study conception and design, manuscript drafting, and data analysis. L X and J L contributed to course delivery and teaching practice. All authors reviewed and approved the

final manuscript.

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Data Availability

The de-identified dataset used for analysis may be made available from the corresponding author on reasonable request, subject to institutional and ethical restrictions.

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Tables

Table 1 to 3 are available in the Supplementary Files section.

Figures

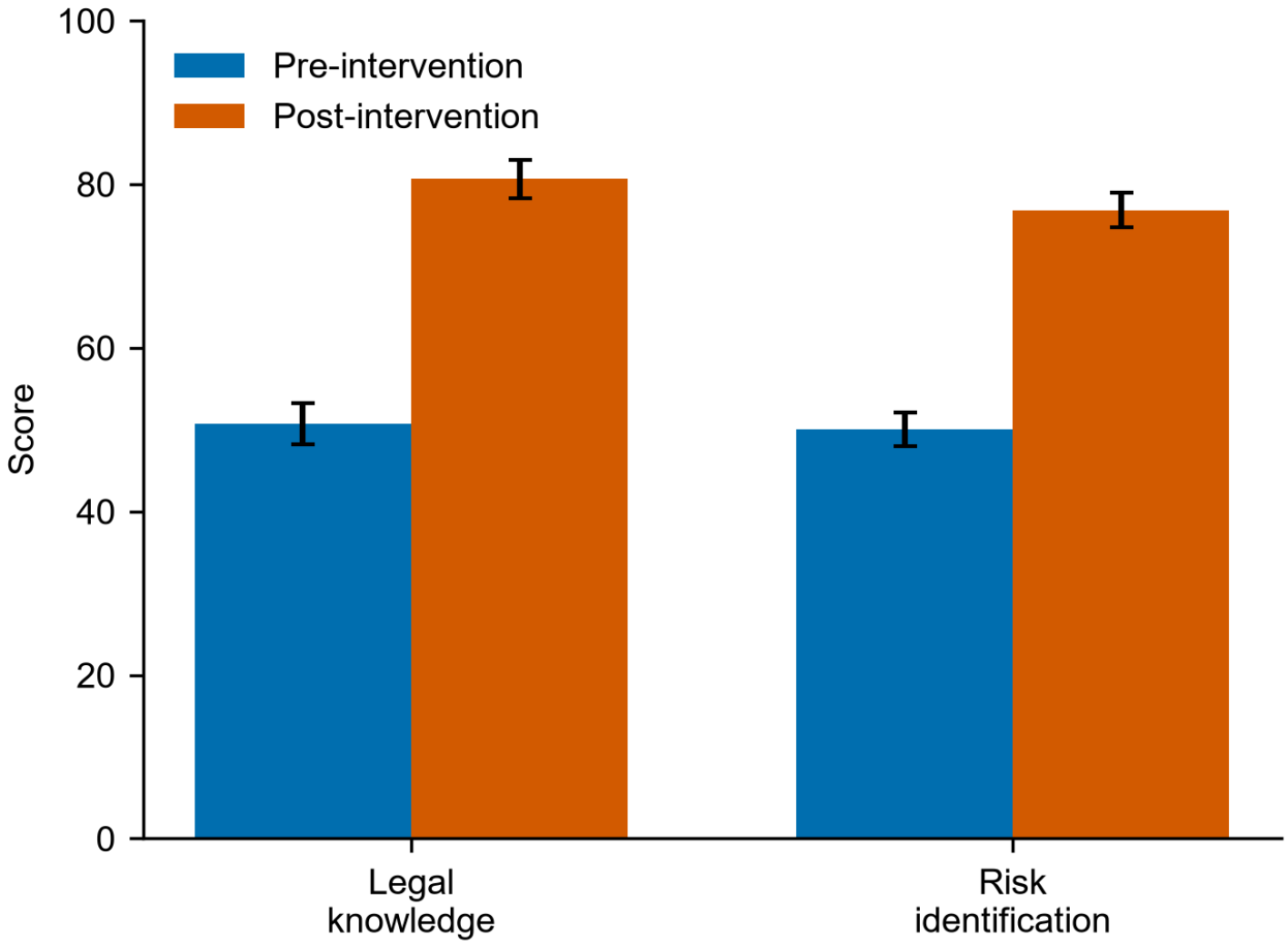


Figure 1

Changes in the two primary outcomes, legal knowledge and clinical legal risk identification, before and after the case-based health law teaching intervention. Error bars indicate 95% confidence intervals.

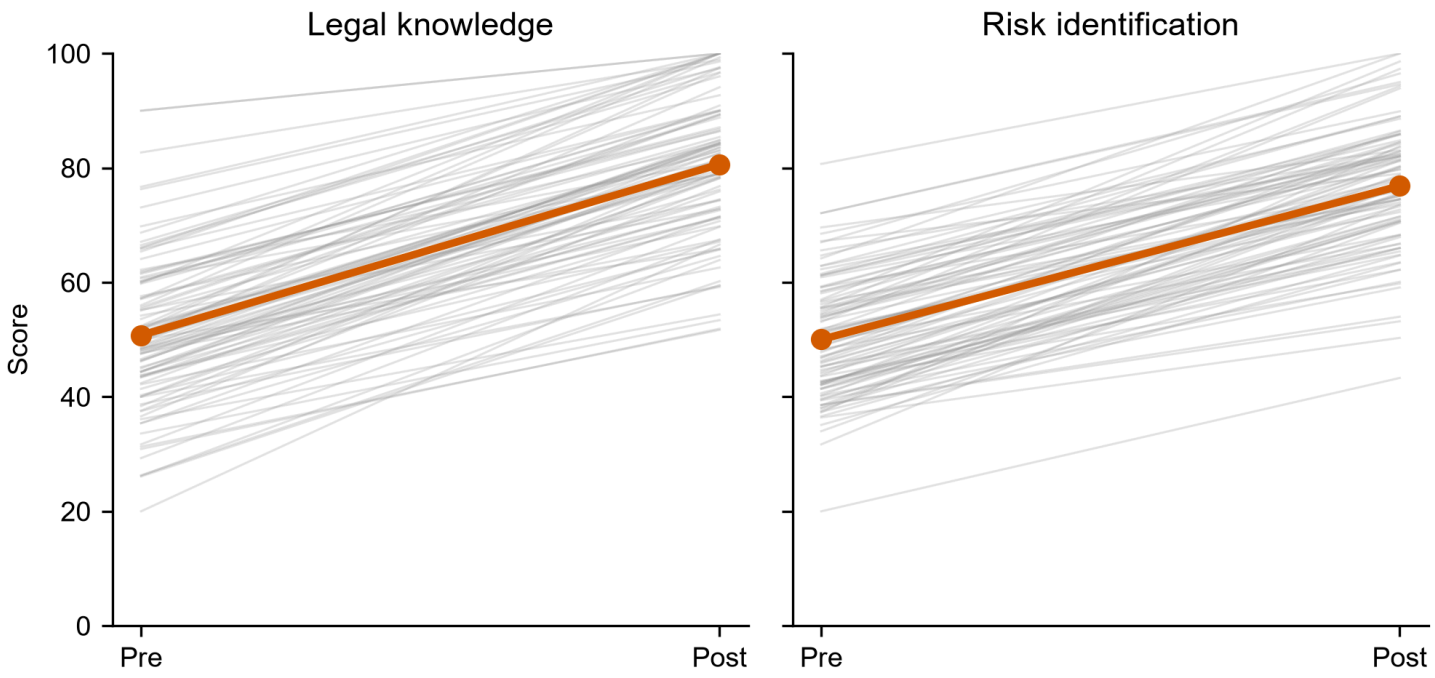


Figure 2

Individual-level changes in legal knowledge and clinical legal risk identification before and after the intervention. Thin gray lines represent individual students, and orange lines represent group means.

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- Table1.docx
- Table2.docx
- Table3.docx
- Supplementarymaterials.docx